Advocacy. Action. Answers on Aging.

National Association of Area Agencies on Aging
1730 Rhode Island Avenue, NW, Suite 1200 / Washington, DC 20036 / Tel: 202-872-0888 / Fax: 202-872-0057 / www.n4a.org

May 29, 2009

Ms. Charlene Frizzera
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services

Ms. Cindy Mann
Director of the Center for Medicaid and State Operations
P.O. Box 8010
Baltimore, Maryland 21244-8010

Attention CMS-2287-P2

Dear Acting Administrator Frizzera and Director Mann:

The following comments by the National Association of Area Agencies on Aging are in response to the partial rescission of the targeted case management Interim Final Rule (IFR) (CMS-2237-IFC) posted in the *Federal Register* on May 6, 2009.

While we appreciate that CMS has recognized the IFR on targeted case management services "may unduly restrict beneficiary access to needed covered case management services, and limit States flexibility in determining efficient and effective delivery systems for case management services," we remain very concerned that the new proposed rule does not address several issues n4a raised in its January 29, 2008 comment letter to CMS (see attachment).

We remain very concerned that the new definitions and requirements under the IFR would apply more broadly to Medicaid as a whole, which could adversely impact 1915(c) state waiver programs, Money Follows the Person demonstration grant initiatives, and state single point of entry models such as Aging and Disability Resource Centers.

In response to concerns from a broad range of state and national organizations about the IFR, Congress delayed implementation of the regulations until June 30, 2009. In enacting the moratorium, Congress made a clear statement that the previous Administration had exceeded the original intent of Section 6052 of the Deficit Reduction Act of 2005 and that CMS should review the DRA provisions and preserve legitimate case management services for vulnerable Medicaid-eligible individuals.

Therefore, we ask that CMS carefully reconsider the approach it has taken by only partially addressing the issues with the IFR, and propose a full rescission of the targeted case management regulations developed by the previous Administration.

We commend CMS for removing the following provisions under the partial rescission:

- the overly restrictive definition of case management services for transitioning individuals from institutions to the community under §440.169(c) and related requirements under

§441.18(a)(8)(viii), which would have imposed new limits on when case management services can be claimed by shortening the allowable period from 180 days to 60 days for stays no fewer than 180 days in duration and 14 days for stays of fewer than 180 days;

- the requirement that case management services be provided on a one-on-one basis to eligible individuals by one case manager under §441.18(a)(5) and the prohibition on providers of case management services from exercising the state Medicaid agency's role to authorize or deny other services under the plan as outlined in §441.18(a)(6);
- payment methodology changes that case management services be billed in units of service that must not exceed 15 minutes under §441.189a)(8)(vi);
- exclusions on federal financial participation (FFP) for case management activities that are an integral component of other covered Medicaid services in §441.18(c)(1), administrative activities integral to other non-medical programs in paragraph (c)(4), and claiming administrative FFP for case management activities in paragraph (c)(5); and
- references to certain types of programs where FFP would be excluded, which would have limited state options for the delivery of case management services in §441.18(c)(2) and (c)(3).

However, we remain very concerned that several harmful provisions were not addressed under the partial rescission:

- the freedom of choice requirement under §431.51(c) only includes exceptions for two target groups (individuals with developmental disabilities and chronic mental illness), where a designated agency can be selected to serve as a single source provider of case management services, which *would disrupt case management systems where states have designated their AAA network to provide case management to older adults*;
- FFP would not be payable until the date that an individual leaves the institution, is enrolled with the community case management provider and is receiving medically necessary services in the community setting as specified in §441.18(a)(8)(vii)(D) and (E), which *would place significant cost burden on case management providers under Money Follows the Person and waiver programs*;
- the requirement that case management services be provided by only one case manager for each individual, which *would affect quality of service for individuals who fall within more than one target group and have multiple conditions and special needs*;
- the requirement that individuals have the choice of any qualified provider agency under §441.18(a)(1), which *would present problems for states that have a designated provider network for case management services as part of single entry point systems such as Aging and Disability Resource Centers*;
- the requirement under §441.18(a)(1) would also permit providers of services to write care plans and provide case management services, *causing an inherent conflict of interest that would make it possible for a case manager to develop a care plan favorable to their provider agency that would not necessarily be in the best interest of the consumer*;
- rule changes under §441.18(a)(2) and (3) giving consumers the option whether to receive case management services, which *could impair consumers' ability to successfully transition back into the community and result in inappropriate long-term care service selection and thereby increase Medicaid costs due to unnecessary medical expenses and repeat hospitalizations*;
- the prohibition on case management providers serving as gatekeepers under Medicaid, which *could undermine systems in place that have streamlined the eligibility determination process and cause unnecessary delays in consumers receiving services*; and
- the prohibition on payment methodologies that bill under a "bundled" rate, which *could lead to fragmentation in state systems, multiple providers duplicating activities, and decreased access to home and community-based services through single entry point systems*.

In conclusion, we urge you to fully rescind the IFR that does not serve the best interests of consumers and would undermine advancements that have been made by many states in their Medicaid systems to provide quality person-centered case management services. Should you have any questions about the issues we have raised on behalf of the Aging Services Network, please do not hesitate to contact K.J. Hertz at 202.872.0888 if we can be of any assistance.

Sincerely,

Sandy Markwood
Chief Executive Officer
National Association of Area Agencies on Aging (n4a)

Attachment: January 29, 2008 n4a Comment Letter to CMS